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Family Information Form

Today's Date _____

Father's Name: _____ Age: _____ DOB: _____

Mother's Name: _____ Age: _____ DOB: _____

Relationship Status: _____

Address 1: _____

City/Zip: _____

Address 2 (if applicable): _____

City/Zip: _____

Best phone numbers to reach you:

Home: _____ Father's Cell: _____

Mother's Cell: _____ Other: _____

Email (Father): _____

Email (Mother): _____

Employment/School (Father): _____

Employment/School (Mother): _____

Children and their ages:

1. _____

2. _____

3. _____

4. _____

Other Family Members:

Present Health Concerns: _____

Current Medications: _____

Previous Counseling: _____

What brings you here? _____

What are your goals for counseling? _____
